TOLL GATE RADIOLOGY

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CERVICAL SPINE CLINICAL QUESTIONNAIRE

NAME: _____ DATE: _____

1. Why has your doctor sent you for this test? Did he/she give you a specific diagnosis?

_____

_____

_____

_____

2. Please describe what specific complaints/symptoms have been most bothersome to you?

_____

_____

_____

3. How long have you had these complaints/symptoms? _____

4. Do you have a history of cancer? If so, what type? _____

5. Are these symptoms the: ☐ same ☐ better ☐ worse

6. Do you have neck pain? ☐ yes ☐ no

7. Do you have pain, numbness, weakness or tingling in any of the following areas:

	Right	Left
Shoulder	☐	☐
Upper Arm	☐	☐
Elbow	☐	☐
Lower Arm	☐	☐
Hand and Fingers	☐	☐

Which fingers are most involved? _____

8. Do you have bowel and/or bladder problems? ☐ yes ☐ no

9. Do you have leg weakness or tingling? ☐ yes ☐ no

10. Have you had a prior significant injury to your neck/spine? ☐ yes ☐ no

If yes, please describe:

_____

_____